the mother would be endangered if the pregnancy were carried to term.

(b) A procedure that is not covered under this section will be covered under General Relief Medical to the extent provided in 7 AAC 47. (Eff. 8/18/79, Register 71; am 2/19/93, Register 125)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.050
AS 47.07.030

7 AAC 43.145. REPORTS. The division may request, at its discretion, a copy of the full operative report, interpretation of any film, or a pathologist's report on tissue removed. When a procedure requires an operative report or particular explanation prior to payment, payment to the physician and the hospital will be subject to receipt by the division of the physician's operative report or explanation. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.150. OUT-OF-STATE SERVICES. Payment for services provided to Alaska medicaid recipients outside the State of Alaska will be limited to the lesser of

(1) the rate established by the medicaid agency in the state where the service was provided; or

(2) the physician's usual and customary charge. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

Article 3. Long-Term Care — Intermediate Care Facilities and Skilled Nursing Facilities

7 AAC 43.170. CONDITIONS FOR PAYMENT. (a) Requirements for payment under medicaid as an SNF or ICF are that

(1) the facility has been certified by the division as being in compliance with federal certification requirements, as follows:

subject to medicare's deductible (there is no coinsurance); prior hospitalization is not required; the division will pay the deductible. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

Article 16. Family Planning Services

7 AAC 43.825. PROGRAM. Except as limited under 7 AAC 43.140, family planning services will be covered by medicaid when provided by a family planning clinic of the division of public health, a local health department, a student health service, a private family planning clinic, or a private physician. Except as limited under 7 AAC 43.140, drugs, supplies, devices, and medical procedures provided by a physician or under physician supervision will be covered under this chapter. (Eff. 8/18/79, Register 71; am 2/19/93, Register 125)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.050

7 AAC 43.830. PAYMENT. Payment for drugs, supplies, devices, and medical procedures will be made in accordance with the provisions of this chapter. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.835. DEFINITION. In 7 AAC 43.825 — 7 AAC 43.835, "family planning services" refers to those services and materials provided with the purpose of postponing, avoiding, or terminating pregnancy, including the dispensing of birth control drugs and devices for males and females, and the performance of vasectomies, sterilizations, and abortions for the purpose of avoiding or terminating pregnancy, except as limited under 7 AAC 43.140. (Eff. 8/18/79, Register 71; am 2/19/93, Register 125)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.050

Article 17. Rural Health Clinic Services

7 AAC 43.850. CONDITIONS FOR PAYMENT. For payment under medicaid, a rural health clinic must

(1) have been certified to the division as being in compliance with federal certification requirements;

(2) be enrolled as a participant in medicare;

(3) comply with the requirements of 7 AAC 43.670 — 7 AAC 43.709. (Eff. 8/18/79, Register 71; am 5/5/84, Register 90; am 6/27/84, Register 91)

Authority: AS 47.05.010 AS 47.07.010

7 AAC 43.855. COVERED SERVICES. Any medical service typically furnished by a physician in an office or as a physician home visit is reimbursable as a rural health clinic service, whether performed by a physician, nurse practitioner, or physician assistant. Rural health clinic services also may be furnished at the recipient's residence or at a hospital or other medical facility. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.860. PAYMENT. Payment will be made to a facility for services provided to recipients according to the following schedules:

(1) services covered under part B of medicare and included in the facility's flat rate will be paid at the rate established by the medicare program;

(2) services not covered by medicare that are covered under this chapter will be reimbursed separately from services covered under (1) of this section;

(3) visiting nurse care will be reimbursed for those individuals who are "homebound," that is, persons who are confined to their place of residence because of a medical or health condition. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.865. MEDICARE COVERAGE. For OASDI recipients 65 years of age or older, or those disabled persons under 65 who are eligible for medicare, every effort must be made by the facility to use the benefits of 42 C.F.R. 405.201 — 405.488 part B of medicare before billing the division. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

Article 18. Outpatient Surgical Clinic Services

7 AAC 43.875. COVERED SERVICES. (a) The services rendered by an outpatient surgical clinic must be medically necessary preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to patients.

(b) The facility may not provide services or other accommodations for patients to stay overnight.

(c) The services of physicians, anesthesiologists, radiologists, and dentists must be billed separately from the billing submitted by the surgical clinic. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.880. CONDITIONS FOR PAYMENT. For payment under medicaid, an outpatient surgical clinic must

(1) have a system to transfer patients requiring emergency admittance or overnight care to a fully licensed, medicaid-enrolled facility following any surgical procedure performed at the outpatient surgical clinic;

(2) comply with the requirements of 7 AAC 43.670 — 7 AAC 43.709;

(3) have a division-approved plan of utilization review;

(4) have a current provider agreement on file with the division. (Eff. 8/18/79, Register 71; am 5/5/84, Register 90; am 6/27/84, Register 91)

Authority: AS 47.05.010 AS 47.07.070

7 AAC 43.885. PAYMENT. Payment for services rendered by an outpatient surgical clinic to recipients will be paid in accordance with 7 AAC 43.670 — 7 AAC 43.709. This payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the recipient while in the clinic. The payment excludes the physician's fee, radiologist's fee, and anesthesiologist's fee. (Eff. 8/18/79, Register 71; am 5/5/84, Register 90; am 6/27/84, Register 91)

Authority: AS 47.05.010 AS 47.07.070

7 AAC 43.890. BILLING RATE. Repealed 5/5/84.

7 AAC 43.895. REPORTS. (a) The division may request, at its discretion, a copy of the full operative report, interpretation of any film, or a pathologist's report on tissue which is removed. When a procedure requires an operative report or particular explanation before payment, payment to the facility will be subject to the receipt of the physician's operative report or explanation for evaluation by the division.

(b) A copy of the facility's billing invoice will normally provide sufficient itemization of the procedures and charges billed. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

Article 19. Chiropractic Services

7 AAC 43.910. CONDITIONS OF AND LIMITATIONS ON PAYMENT. (a) For payment under medicaid, a chiropractor

(1) must be licensed by the Alaska Board of Chiropractic Examiners;

(2) must meet the federal standards established for Medicare at 42 CFR 405.232(b); and

(3) shall comply with the requirements of 18 AAC 85.

(b) Medicaid payment for chiropractic services is subject to the following payment limitations:

(1) services not described in 7 AAC 43.920, including examinations, consultations, supplies, and full spine x-rays, are not covered services;

(2) reimbursement will be made for no more than 24 visits in a calendar year for a recipient;

(3) reimbursement will be made for no more than three division-assigned chiropractic x-ray billing codes during a calendar year for a recipient;

(4) reimbursement for a treatment consisting of manual manipulation to correct a subluxation of the spine will be the chiropractor's usual and customary charge, but will not exceed $30;

(5) reimbursement for x-rays necessary for diagnosis of subluxation of the spine will be the chiropractor's usual and customary charge, but will not exceed $65 for each division-assigned chiropractic x-ray billing code; and

Maximum Medicaid Payment Rates for
Listed Pediatric and Obstetric Practitioner Services
Calendar Year 1996

PROCEDURE CODE	PROCEDURE DESCRIPTION	STATE max/avg	SMSA max/avg	OTHER max/avg
	OFFICE/OUTPATIENT MEDICAL SERVICES			
	New Patient			
99201	Office Services-problem focused	60/53	60/53	60/52
99202	expanded problem focused	80/63	70/62	80/69
99203	low complexity	125/77	90/73	125/89
99204	moderate complexity	144/114	144/112	144/124
90205	high complexity	197/158	197/165	197/111
	Established Patient			
99211	Office Services-minimal	35/23	29/23	35/24
99212	problem focused	50/38	50/40	43/36
99213	expanded problem/low complexity	76/47	76/45	76/57
99214	moderate complexity	108/67	80/66	108/73
99215	high complexity	140/101	120/99	140/107
	OFFICE OR OTHER OUTPATIENT CONSULTATIONS			
	New or Established Patient			
99241	Physicians typically spend 15 minutes	138	104	138
99242	Physicians typically spend 30 minutes	150	104	150
99243	Physicians typically spend 40 minutes	193	165	193
99244	Physicians typically spend 60 minutes	272	200	272
99245	Physicians typically spend 80 minutes	378	200	378
	CONFIRMATORY CONSULTATIONS			
	New or Established Patient			
99271	Presenting problems are self limited or minor	100	100	100
99272	Presenting problems are of low severity	102	102	102
99273	Presenting problems are of moderate severity	90	90	90
99274	Presenting problems are of moderate to high sev.	179	179	179
99275	Presenting problems are of moderate to high sev.	150	150	150
	HOME SERVICES			
	New Patient			
99341	Presenting problems are of low severity	80	80	80
99342	Presenting problems are of moderate severity	100	100	100
99343	Presenting problems are of high severity	129	129	129

Maximum Medicaid Payment Rates for
Listed Pediatric and Obstetric Practitioner Services
Calendar Year 1996

PROCEDURE CODE	PROCEDURE DESCRIPTION	STATE max/avg	SMSA max/avg	OTHER max/avg
	Established Patient			
99351	Patient is stable, recovering or improving	40	40	40
99352	Patient responding inadequately to therapy	74	74	74
99353	Patient unstable or developed complication	110	110	110
PROLONGED SERVICES				
99354	Prolonged physician service; first hour	115	115	115
99355	each additional 30 minutes	52	52	52
99358	Prolonged evaluation; first hour	NA	NA	NA
99359	each additional 30 minutes	NA	NA	NA
PREVENTIVE MEDICINE				
	New Patient			
99381	Initial history/exam, infant (age under 1)	70/61	65/60	70/65
99382	early childhood (age 1-4)	87/62	70/61	87/78
99383	late childhood (age 5-11)	110/60	74/59	110/73
99384	adolescent (age 12-17)	85/60	81/59	85/73
	Established Patient			
99391	Periodic reevaluation, infant (age under 1)	65/39	52/43	65/34
99392	early childhood (age 1-4)	71/30	52/41	71/22
99393	late childhood (age 5-11)	87/31	59/42	87/22
99394	adolescent (age 12-17)	88/34	67/46	88/24
COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION				
	Preventive Medicine, Individual Counseling			
99401	Counseling to healthy individual; 15 minutes	NA	NA	NA
99402	30 minutes	NA	NA	NA
99403	45 minutes	NA	NA	NA
99404	60 minutes	NA	NA	NA
	Preventive Medicine, Group Counseling			
99411	Counseling in a group setting; 30 minutes	NA	NA	NA
99412	60 minutes	NA	NA	NA
	Other preventive medicine services			
99420	Admin & Inter of health risk assessment inst.	NA	NA	NA
99429	Unlisted preventive medicine service	NA	NA	NA
NEWBORN CARE				
99432	Newborn care other than hospital setting	80	80	80

Maximum Medicaid Payment Rates for
Listed Pediatric and Obstetric Practitioner Services (cont.)
Calendar Year 1996

PROCEDURE CODE	PROCEDURE DESCRIPTION	STATE max/avg	SMSA max/avg	OTHER max/avg
IMMUNIZATION INJECTIONS				
90700	Immunization, active; DTaP	NA	NA	NA
90701	Immunization (DPT)	10/6	7/6	10/8
90702	diphtheria and tetanus toxoids (DT)	20	12	20
90703	tetanus toxoid	10	10	10
90704	mumps virus vaccine, live	NA	NA	NA
90705	measles	19	15	19
90706	rubella	NA	NA	NA
90707	measles, mumps, and rubella	34/6	7/5	34/10
90708	measles and rubella	NA	NA	NA
90709	rubella and mumps	NA	NA	NA
90710	measles, mumps, rubella & varicella vac.	NA	NA	NA
90711	DPT and inj. poliomyelitis vaccine	NA	NA	NA
90712	poliovirus, oral	16/4	5/4	16/6
90713	poliomyelitis vaccine	10	10	10
90714	typhoid vaccine	NA	NA	NA
90716	varicella vaccine	47	47	47
90717	yellow fever vaccine	NA	NA	NA
90719	diphtheria toxoid	7	7	7
90720	DPT & HIB	NA	NA	NA
90721	DTaP & HIB	NA	NA	NA
90724	influenza virus vaccine	22	18	22
90725	cholera vaccine	16	16	16
90726	rabies vaccine	NA	NA	NA
90727	plague vaccine	NA	NA	NA
90728	BGC vaccine	NA	NA	NA
90730	hepatitis A vaccine	NA	NA	NA
90732	pheumococcal vaccine, polyvalent	21	15	21
90733	meingococcal polysaccharide vaccine	NA	NA	NA
90737	Hemophilus influenza B	25/8	10/6	25/11
90741	Immunization, passive; immune serum globulin	42	42	10
90742	specific hyperimmune serum globulin	50	50	50
90744	Immunization, active Hep B. newborn to 11 years	NA/6	NA/6	NA/10
90745	11 to 19 years	NA/22	NA/24	NA/19
90749	Unlisted immunization procedure	25	25	25

Maximum Medicaid Payment Rates for
Listed Pediatric and Obstetric Practitioner Services (cont.)
Calendar Year 1996

PROCEDURE CODE	PROCEDURE DESCRIPTION	STATE max/avg	SMSA max/avg	OTHER max/avg
MATERNITY CARE AND DELIVERY				
Incision				
59000	Amneiocentesis, any method	220	220	175
59012	Cordocentesis (inrauterine), any method	NA	NA	NA
59015	Chorionic villus sampling, any method	NA	NA	NA
59020	Fetal contraction stress test	200	200	200
59025	Fetal non-stress test	77	65	77
59030	Fetal scalp blood sampling	98	98	98
59050	Internal fetal monitoring	130	130	50
59051	interpretation only	NA	NA	NA
59100	Hysterotomy, abdominal	1377	1377	1377
Excision				
59120	Surgical treatment of ectopic pregnancy	2324	1784	2324
59121	tubal or ovarian, without	1960	1400	1960
59130	abdominal pregnancy	1329	1329	1329
59135	interstitial, uterine pregnancy-total hyster.	1794	1794	1794
59136	interstitial, uterine preg. w/part. resection	1440	1440	1440
59140	cervical, with evacuation	1329	1329	1329
59150	Laparoscopic treatment of ectopic pregnancy	892	892	892
59151	with salpingectomy	1232	1232	1232
59160	Curettage, postpartum (separate procedure)	700	550	700
Introduction				
59200	Insertion of cervical dilator	40	40	40
Repair				
59300	Episiotomy by other physician	75	75	75
59320	Cerclage or cervix, during pregnancy; vaginal	NA	NA	NA
59325	abdominal	541	541	541
59350	Hyserorrhaphy of ruptured uterus	1377	1377	1377
Delivery, Antepartum and Postpartum care				
59400	Total obstetric care (if TPL exists)	1394/NA	1394/NA	1394/NA
59409	Vaginal delivery only	1267/967	890/895	1267/1140
59410	Vaginal delivery	1327/1001	950/948	1327/1144
59412	External cephalic	300/262	300/263	245/258
59414	Delivery of placenta	227/226	227/227	227/224
59425	Antepartum care only; 4-6 visits	NA/59	NA/58	NA/65
59426	7 or more visits	NA/59	NA/59	NA/70
59430	Postpartum care	66/62	60/63	66/61

Maximum Medicaid Payment Rates for
Listed Pediatric and Obstetric Practitioner Services (cont.)
Calendar Year 1996

PROCEDURE CODE	PROCEDURE DESCRIPTION	STATE max/avg	SMSA max/avg	OTHER max/avg
Cesarean Delivery				
59510	Total obstetric w/cesarean (if TPL exists)	NA	NA	NA
59514	Cesarian delivery only	2144/1071	1540/1029	2144/1177
59515	Cesarian, including postpartum care	2210/1113	1600/1002	2210/1364
59525	Subtotal or total hyst. after cesarian delivery	1980/NA	1980/NA	1980/NA
Abortion				
59812	Incomplete abortion	700	700	700
59820	Missed abortion; first trimester	550	550	540
59821	Missed abortion; second trimester	459	459	459
59830	Treatment of septic abortion	410	410	410
59840	Induced abortion, by dilation and curettage	450	375	450
59841	Induced abortion, by dilation and evacuation	850	850	850
59850	Induced abortion, by one or more intraamniotic inj.	150	150	150
59851	w/dilation & curettage and/or evacuation	807	807	807
59852	w/hysterotomy(failed intra-amniotic injection)	1377	1377	1377
59855	Induced abortion w vaginal suppositories	NA	NA	NA
59856	w dilation and curettage	NA	NA	NA
59857	w hysterotomy	NA	NA	NA
Other Procedures				
59870	Uterine evac & curettage for hydatidiform mole	NA	NA	NA
59899	Unlisted, maternity care and delivery	NA	NA	NA

NA = Has not been billed; if billed, payment will be at 100%

Usual, customary, and prevailing methodology is used to determine rates for the pediatric and obstetric practitioner services. Maximum rates have not changed, except to the extent necessary to correspond to new CPT-4 codes. Changes to average rates are nominal. Reprofiling has not been done since January 1, 1991 due to budget constraints. An RBRVS type methodology rate will be in place as of February 1, 1997.

The only Standard Metropolitan Statistical Area (SMSA) in Alaska is the greater Anchorage area (from Eklutna to Girdwood, including Chugiak and Eagle River). "Other" is the remainder of the state.